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ABSTRACT

In reference to the significance of a marginal profession, 44 Missouri chiropractors practicing in 20 rural counties (total enumeration) were compared with 39 randomly selected Kansas City chiropractors to determine the following characteristics: (1) social background; (2) place history (at time of birth, start of school; termination of 8th grade, and termination of high school); (3) progress in entering the field (education); and (4) nature of the practicing chiropractor and his practice. Findings indicated that rural chiropractors were: (1) from white collar families with entrepreneural tendencies; (2) pursuing this field out of a need to fulfill an entrepreneural imperative, rather than a specific career calling; (3) practicing in areas comparable to their place of origin; and (4) trained in or adjacent to their state of origin. It was concluded that the concepts of localism and client control influenced this marginal profession, as competition with and isolation from colleagues renders the practitioner vulnerable to client control while localism furthers community acceptance. It was argued, therefore, that localism and client control were interrelated influences on the chiropractor practice. (JC)

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A MARGINAL PROFESSION IN RURAL AREAS:

THE CASE OF RURAL CHIROPRACTORS

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RURAL CHIROPRACTORS

Introduction

Chiropractic doctors offer an alternative philosophy of healing to the regular medical professions as represented by medical and osteopathic doctors. The founder of the profession, Daniel David Palmer, had a non-medical background and accounts of the development of chiropractics represent it as a discovery (1895) with many of the characteristics of a social movement - an ideology (the chiropractic philosophy), charismatic leadership (D. D. Palmer), and opposition to the establishment (organized medicine).

Beginning in the Midwest, chiropractic retains its greatest impact in that region with only Iowa, Kansas, Missouri, New Hampshire and South Dakota having a chiropractor/population ratio of more than 15/100,000 (Health Resources Statistics 1974). Although relatively few persons make any use of chiropractors, the National Health Survey reports that farm residents are about twice as likely as metropolitan residence to use chiropractors. McCorkle has interpreted the appeal of chiropractic healing in rural Iowa to the consonance of the chiropractic philosophy to beliefs of rural people of that area about health.

All states with the exception of Louisiana now license chiropractors although with different requirements and constraints of practice. There are about 20,000 licensed practitioners in the 49 states where they are licensed to practice with an estimated 15,500 in active practice. Currently there are 10 training schools approved by one of the two (competing) professional associations. Two of the colleges are in Missouri; Cleveland Chiropractic College, Kansas City and Logan Chiropractic College,

St. Louis. Palmer College of Chiropractic, Davenport, Iowa is the largest training institution; its 324 graduates in 1972 accounted for almost exactly half of the total graduates (653) from chiropractic colleges for that year.

Chiropractic treatment consists primarily of adjustments of parts of the body, especially the spinal column. The rationale is that the nervous system largely determines the state of health and that any interference with this system impairs normal functions and lowers the body's resistance to disease (p. 47, Health Resources Statistics, 1974). Thus chiropractic represents a general philosophy of healing over a broad spectrum of ailments. However, by convention, the use of chiropractors by most people is limited to quite specific musculoskeleton conditions. Within the profession itself there is division over expansion of types of therapy. So there are the traditionalists and expansionists in the profession generally represented by the International Chiropractic Association and the American Chiropractic Association respectively.

Chiropractors as a Marginal Profession

There is little information, however, about chiropractors in the sociological literature on professions and occupations. Walter Wardwell has been the major source of sociological analysis of chiropractors. His article of 1952 in Social Forces raises many questions about chiropractic as a profession which is pertinent today. The most recent of his discussions can be found in the Handbook of Medical Sociology, 2nd edition, 1972. Much of Wardwell's discussion of chiropractors centers on the marginal status of the profession and what he calls an "ideology of an oppressed minority". He points out, "The ideology gives the chiropractor, in his daily practice, a sense of carrying out an important mission --

that of bringing help to the afflicted that medicine cannot cure." (p. 262, Handbook) There is almost no professional contact between chiropractors and the regular medical professions on the national level and the American Medical Association regards them as quacks. However, at the community level there may be some relationships between chiropractors and medical practitioners.

Of interest to us is the selection by incumbents of this profession and their career progression. Specifically, what is the backgrourd of rural chiropractors, what is their place history, what is the progression in entering the profession, and what is their practice like?

The Samples

The 44 rural chiropractors of this study represent a complete enumeration of those practicing in a 20-county area of Missouri with the exception of two who could not be interviewed. This area has served as a "laboratory" for the observation of health personnel over an extended period of time. It is rural to the extent that no place is as large as 10,000 population and it generally is outside the influence of metropolitan centers. We have extensive data on medical doctors in the area and this will be used for limited comparisons. In the area, the number of chiropractors has increased slowly since 1950 while the number of other health practitioners (medical doctors, osteopathic doctors, dentists) has declined steadily.

The metropolitan sample was selected randomly from chiropractors listed in practice in the Kansas City, Missouri telephone directory. The number interviewed (39) approximated the number of rural chiropractors.

Because of the small number of rural chiropractors, we present the

data in a comparative descriptive manner.

Social Backgrounds of Rural Chiropractors

Because of the marginality of the chiropractic profession, we had supposed that chiropractors would come from lower status families as indicated by predominantly low status occupations of fathers. The data forced us to reconsider this hypothesis. Among rural chiropractors, the modal category of father's occupation was farm operator (38.6 percent). The next highest category was from among proprietors, managers and officials (18.2 percent); in addition, in other white collar categories, 7 percent were professionals, and 11 percent were sales-clerical. Thus seventy percent of the rural chiropractors were from white collar or farm operator families with only thirty percent from blue collar non-farm operator families. The fathers of spouses of rural chiropractors were concentrated even more heavily in the farm operator category (47.7 percent) and 34 percent in the blue collar nonfarm operator category. Fathers of rural chiropractors were notably absent in the health professions with one being a chiropractor and one a dentist. None of the spouses of rural chiropractors were in the health professions.

The occupations of fathers of urban and rural chiropractors differed somewhat with the greatest difference being fewer farm operators among fathers of urban D.C.'s; at the same time, more of the urban fathers were classified as professionals and as proprietors and managers. Among blue collar workers, there were more craftsmen (to some extent status of craftsmen in urban areas appears to equal farm operators in rural areas).

The general pattern of father's occupation seems to prevail in both rural and urban settings -- relatively few were from lower status occupations (operatives, service workers, laborers) and relatively few from the

highest status occupations and in particular the medical professions.

Another way of assessing the social status background of rural chiropractors is to compare them with medical doctors from the same area. The data on medical doctors was collected in 1961 and of course the comparison suffers from the elapse of time. It is of interest to observe, however, that the proportions of chiropractors and medical doctors whose fathers were farm operators was quite similar as was the proportions in the proprietor- manager category. The biggest difference was in the professional category in which 31 percent of the fathers of medical doctors were placed compared with 7 percent of the fathers of chiropractors. Furthermore, most of the professional category for medical doctors represented those in medical professions (19 of 22). While about 30 percent of the rural chiropractors were from blue collar families only about 10 percent of the medical doctors were.

The question is how to interpret these findings? The interpretation hinges on how we regard the status of farm operators. Unfortunately, we do not have enough information on the size and characteristics of the farms to distinguish among farm operators. But in general we can consider farm operators together with proprietors and professionals to represent the "backbone" entrepreneural occupations of rural communities. And since, as we shall see, most of the rural chiropractors were reared in rural communities, we can conclude that rural chiropractors were not from lower status families of rural communities. At the same time, there is some evidence that the family status of medical doctors was somewhat higher. Aside from such comparisons the data indicate that the bulk of rural (as well as metropolitan) chiropractors came from families whose occupations suggested entrepreneural socialization. The chiropractic

profession seems to be congruent with such a background.

Place History of Rural Chiropractors

Career can best be thought of as a process and choice of location of practice can be regarded as one aspect of career choice. In this section we will examine the relationship of youth locations to practice location by means of a place history. The place history is defined as locations of individuals at times of designated events in their lives. Since educational events are important in professional careers, we have selected such events (in addition to place of birth) to deliniate the early years of the place history. The hypothesis is that location of present practice should be related to youth locations. The events are: birth, started school, finished 8th grade, finished high school. The locations can be identified in a number of ways. We are particularly interested in whether current practice is the same place as youth location (hometown), if it is similar in size to youth locations, and if it is in the same state as youth locations.

In considering size we have divided places at the 10,000 population level because the largest place in the 20-counties approaches but does not exceed that population. Chiropractors practicing in the 20-county rural area were very likely to have had youth residences in places of under 10,000 population (Table 1). It also appears from this table that from birth through high school the size characteristics of their locations remained quite stable. The youth locations of the metropolitan chiropractors was quite different with regard to size of place with about 2/3 of them residing in places of 10,000 or more at the time of graduation from high school

When we examine the youth locations with regard to identity with their

Place History

Residence at time of:

	Birth	Started school	Finished 8th grade	Finished high school
1. Same place as present practice				
Rural*	29.5	34.0	36.3	36.3
Metropolitan**	58.9 (-17.9)	64.1 (17.9)	64.1 (15.4)	61.6 (15.4)
2. Other-Missouri				
Rural	29.5	27.3	27.3	27.3
Metropolitan	15.4	12.8	12.8	15.4
3. Adjacent to Missouri				
Rural	25.0	25.0	27.3	27.3
Metropolitan	10.3	12.8	12.8	12.8
4. Non-adjacent to Missouri				
Rural	15.9	13.6	9.1	9.1
Metropolitan	15.4	10.3	10.3	10.3

*same place or within 30 miles as measured on a map
**same place or within 30 miles as measured on a map, because of the location of the metropolitan sample this could include residence in Kansas

Table 1

Place History

Size of Place of Residence at:

	Birth	Started school	Finished 8th grade	Finished high school
Under 10,000				
Rural	72.8	68.2	75.0	72.8
Metropolitan	47.2	41.0	41.0	35.9
10,000+				
Rural	27.2	31.8	25.0	27.2
Metropolitan	53.8	5[illegible].0	59.0	64.1

present place of practice and with regard to State, the correspondence is quite sharp. Almost 2 in 5 of the rural chiropractors had finished high school in or near (30 miles) the place in which they were currently practicing. For the metropolitan chiropractors the identity of youth locations and present practice was even greater. This meant that they had grown up in the Kansas City area and had remained there to practice. On the other hand, relatively few chiropractors had youth locations outside of Missouri or in states not adjacent to Missouri. Thus there is a clear localism among chiropractors that can be traced to their early youth. The same localism is apparent in their training years which we will consider now.

The Education of a Chiropractor

Licensure in Missouri now requires four years of professional training and 80 percent of the rural chiropractors had attended four years (77 percent for metropolitan chiropractors). However 52 percent of the rural compared with 23 percent of the metropolitan chiropractors had not attended an undergraduate college. The great majority (81 percent) of the rural chiropractors who attended undergraduate school did so in the state compared with 54 percent of metropolitan chiropractors.

Almost all of the rural chiropractors attended one of three schools (Cleveland in Kansas City, 39 percent; Logan in St. Louis, 34 percent; or Palmer in Davenport, Iowa, 21 percent). The professional training of the metropolitan chiropractor was even more concentrated with 77 percent graduating from Cleveland of Kansas City and 10 percent from Logan.

The age of graduation of rural chiropractors from chiropractic college was an interesting bimodal distribution with 27 percent being under 25 years of age and 23 percent being 35 or over. For metropolitan chiropractors

it was similar with 26 percent under 25 and 31 percent 35 or over. The substantial number of chiropractors who graduated from professional school at a relatively late age suggests that for many the decision to enter this profession was relatively late. Other data from the survey tends to confirm this. Only about one-fifth of the rural chiropractors and one-tenth of the metropolitan chiropractors reported that they had decided on the profession before leaving high school (this compares with about 2/3 of the medical doctors from the earlier study of the same rural area who reported they had decided on a medical career by the time they had finished high school). On the other hand, over half had either entered the labor market or were in service at the time they made the decision to enter the profession.

In his earlier study of Massachusetts chiropractors, Wardwell concluded that career decisions were made somewhat casually. Our data seem to support this. The rural chiropractors or members of their family had commonly had experience with chiropractic treatment which was cited as a reason for choosing the profession. But on the whole their reasons for choice of the profession appeared to be quite vague and without the conviction of professional calling.

Characteristics of Chiropractors and their Practices

Rural chiropractors as a group were relatively young with 50 percent being under 45 years of age. Metropolitan chiropractors were somewhat older with one-third under 45 years of age. All but four of the rural chiropractors maintained a full-time practice; three of the four limited their practice because of age or health, the other part-time practitioner had other employment. Two-thirds reported that they worked 40 hours or more a week.

Almost one-third of the rural chiropractors had some form of association with another chiropractor. This was most often a two-member practice none more than three members. There were four husband-wife teams and father-son combinations.

Practices in the area were entirely office based involving virtually no outside support facilities. It was not uncommon for the office to be in a separate area of the family home. Waiting rooms of the offices were similar to those of physicians of the area. However, the work area included the characteristic treatment table and usually X-ray equipment for diagnostic purposes. In other public ways, chiropractors seemed to model their practices on medical and osteopathic doctors of the area. That is they presented a professional image in a doctor-patient relationship.

While chiropractics represents a general philosophy of healing and virtually all the chiropractors maintained a "general" practice, the D.C.'s of the 20 counties reported that most of their patients come to them for conditions of the musco-skeletal system (back, spine, etc.) or the nervous system (including headaches). Only 10 percent indicated that most of their patients used them for "everything". This fits remarkably well with a community survey we did earlier which indicated that 90 percent of those who went to chiropractors did so for conditions of the musco-skeletal or nervous system. Another characteristic of chiropractic patients was that they were in the young and middle adult years with a concentration between 45 - 65. Elderly and especially children were not likely to be chiropractic patients. In addition more than half of the rural chiropractors reported that more of their patients were women (52.3 percent) than men (4.5) with 43.2 percent reporting about equal numbers of men and women. The largest proportion of chiropractic patients were also drawn from blue collar and lower middle income categories of the community. Ninety percent reported

that most of their patients were in the income category $4-10,000 and 77 percent that most were from blue-collar families.

A common statement is that people do not understand the nature of chiropractic practice and there is a strong need felt to educate the public about the advantages of chiropractic treatment. It is also felt that people learn about the advantages of chiropractics largely through word of mouth based on favorable experiences of patients. True to minority status form, there is a general feeling of persecution by the medical profession a situation which the chiropractor siezes upon to identify his professional domain.

There does not appear to be a regular referral network among chiropractors beyond the interchange that takes in those situations of partnerships or other formal associations. This can be attributed in part to the lack of speciality differentiation among chiropractors. While only 20 percent reported that they made regular referrals to M.D.'s or D.O.'s, an additional 64 percent said they made such referrals on occasion. This however should not be construed as a D.C.-M.D.-D.O. network but more nearly a suggestion to a patient that he should consult a physician in some cases. Reciprocal referral from M.D.'s or D.O.'s to chiropractors was even less common; none of the rural chiropractors reported regular referrals from physicians although 45 percent said it occurred occasionally. It appeared that any referral from the past, however casually made, was remembered and reported. The practices of rural chiropractors then appeared to be quite isolated from other chiropractors as well as from other components of the medical profession. This might lead to what Freidson refers to as client control (as distinct from colleague control) where the professional finds support in his clientele and thus is directly influenced by them. The localism of chiropractors, their dependency on word of mouth advertising,

the self-contained nature of their practice all would support this interpretation.

The isolation of chiropractors, however, can be over stated. We have already seen that a substantial proportion were practicing in association with another chiropractor. Furthermore, only 2 of the rural chiropractors did not belong to a professional organization. Also, the chiropractic school remains an important professional influence in that almost 90 percent reported that they maintained a contact with a chiropractic college.

Summary and Discussion

The discussion of chiropractors leads us to speculate on influences in their selection of a marginal profession, and having made that selection, the behavioral sequelae for bolstering and maintaining a marginal role. Central to the discussion is the phenomenon of marginality. The chiropractor is outside the regular medical care system and does not have a clear public mandate to practice. Consequently he must make his place both in the medical care system and with the public. Clearly the profession is a risky one for those who enter it. First we will consider the implications of socialization (social background) for selecting a risk-bearing vocation and secondly the behavior of chiropractors in "reducing role strain" in a marginal profession.

The family background of rural chiropractors suggests entrepreneural socialization. Most of them were from white collar families (especially proprietors and managers) or from families of farm operators who in rural communities represent the entrepreneural class. Furthermore, their career progression suggests that choice of profession was more of an opportunity to fulfill an entrepreneural imperative than a specific career calling. The chiropractic practice is a highly entrepreneural activity in the tradition of independent farm operators and small businessmen. The entrepreneural models provided by

their fathers may have attracted chiropractors to an individualistic profession and provided a tolerance for risk taking in pursuit of vocational objectives.

Once in a marginal profession, the problem is how to establish position and how to function on a day to day basis. Two related concepts which can be considered as derivative from chiropractors' marginality are localism and client control. With regard to localism, the rural chiropractors tended to practice in areas that were much like the communities they grew up in and often in their hometowns. They also received their professional training at schools within the state or an adjacent state. The data for the metropolitan chiropractors also strongly supports the tendency toward localism. Localism can be regarded as a means of dealing with the role of a marginal practitioner. The chiropractors do not have a mandate to practice in the same way medical doctors do. He must win at least partial acceptance from the community in which he practices. Wardell terms this seeking out of community support, "realistic pattern of strain reduction". (11) Localism serves to reduce social distance between practitioner and client and may aid in earning community acceptance. Localism may also be important for the marginal practitioner whose appeal rests on a congruence between the practitioner's philosophy and mode of practice and the client's beliefs about he health and illness as noted previously by McCorkle. (6) It may also be important for the related emphasis on personal and friendly relations with patients which tend to characterize chiropractic practice.

The second characteristic of chiropractors related to their practice in a marginal profession is client control. (1) The situation out of which client control develops is isolation from colleagues. Speaking generally about autonomous practices Freidson says, "Since his colleagues are competitors, he is not likely to solicit their advice or trade information with them, and he certainly will not refer his patients to them for consultation. Thus he remains isolated from his colleagues and relatively free of their control--but at the same time

he is very vulnerable to control by his clients. To keep them, he must give them what they want, or someone else will attract them away." (Handbook, p. 346) Chiropractic practice in the rural area we studied had many of the elements that might lead to client control and there was considerable evidence of it. Within the profession, there is little specialization so interdependencies associated with division of labor do not require colleague relationships. Furthermore the data show no established referral or consultative networks among chiropractors or between chiropractors and medical or osteopathic doctors. In terms of client relationships, chiropractors actively try to educate their patients to the advantages of chiropractic treatment and seek a network of good-will among community members.

It is argued that localism and client control are inter-related. Where the practice is client controlled, it is necessary for the practitioner to be culturally attuned to his patients. Also when the service has to be sold to a clientele, it may be important for the practitioner not to have the status of "outsider". And while the localism of the practitioner may aid in gaining the acceptance in the community the same localism may make client control tolerable to the practitioner.

References

1. Eliot Friedson
Client Control and Medical Practice
American Journal of Sociology, Vol. 65, Jan. 1960, pp. 374-382

2. Eliot Freidson
The Organization of Medical Practice (Chapter 14) in
Howard E. Freeman, Sol Levine and Leo Reeder, Handbook of Medical Sociology
2nd Edition, Prentice-Hall Inc., Englewood Cliffs, New Jersey, 1972.

3. Edward W. Hassinger
Background and Community Orientation of Rural Physicians Compared with Metropolitan Physicians in Missouri
Univ. of Missouri A.E.S. Research Bulletin 822, Columbia, MO., August, 1963.

4. Edward W. Hassinger, Daryl J. Hobbs, F. Marian Bishop and A. Sherwood Baker
Extent, Type, and Pattern of Use of Medical Services in a Rural Ozark Area
Univ. of Missouri A.E.S. Research Bulletin 965, Columbia, MO., 1970.

5. Phylis Lin
The Chiropractor, Chiropractic, and Process: A Study of the Sociology of an Occupation
Ph.D. Dissertation, Univ. of Missouri-Columbia, Dec., 1972

6. Thomas McCorkle
Chiropractic: A Deviant Theory of Disease and Treatment in Contemporary Western Culture
Human Organization, Vol. 20, Spring 1961, pp. 20-23

7. National Center for Health Statistics
Characteristics of Patients of Selected Types of Medical Specialists and Practioners
U.S. Dept. of HEW, Series 10, No. 28, U.S. Govt. Printing Office, Washington, D.C., May 1966.

8. National Center for Health Statistics
Health Resources Statistics 1974
U.S. Dept. of HEW, Health Resources Administration, Rockville, Maryland, 1974.

9. Walter I. Wardwell
A Marginal Professional Role: The Chiropractor
Social Forces, Vol. 30, March 1952, pp. 339-348.

10. Walter I. Wardwell
Limited, Marginal and Quasi-Practioners
Chapter 11 (pp. 250-273) in
Howard E. Freeman, Sol Levine and Leo G. Reeder, Handbook of Medical Sociology,
2nd Edition, Prentice-Hall Inc., Englewood Cliffs, New Jersey, 1972

11. Walter I. Wardwell
The Reduction of Strain in a Marginal Social Role
American Journal of Sociology, Vol. 61, July 1955, pp. 16-25